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DIVISION OF HEALTH CARE  
FINANCE AND POLICY

June 12, 2009

Leslie Kirwan, Co-Chair, Special Commission on the Health Care Payment System  
Secretary, Executive Office for Administration and Finance  
State House, Room 373  
Boston, MA 02108

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Sarah Iselin, Co-Chair, Special Commission on the Health Care Payment System  
Commissioner, Division of Health Care Finance and Policy  
2 Boylston Street, 5<sup>th</sup> Floor  
Boston, MA 02116

Dear Secretary Kirwan and Commissioner Iselin:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 12 health plans that provide coverage for 2.4 million Massachusetts residents, I am writing with regard to the Special Commission on the Health Care Payment System's recent recommendations. We appreciate the Commission's work to date and are supportive of moving toward a more rational payment system that supports safe, timely, efficient, effective, equitable, patient-centered care while reducing costs and significantly slowing future health care cost growth.

The MAHP member health plans have spent many years learning how to manage care across delivery settings and across diverse populations. We expect that experience will be critical to the eventual success of the Commission's proposals. To that end, we would like to share our perspective on a few of the key recommendations for the Commission either to consider in its final report or as issues that it will direct the successor entity to resolve.

**Formation of ACOs & Development of Global Payments**

We believe that the Commission's report needs to address a number of questions regarding the formation of ACOs and the development of global payments. These questions include:

- What are the criteria for a provider entity to be considered an ACO ready to accept global payments;
- What types of services would have to be provided by an ACO;
- What types of services would be included within the global payment, regardless of whether the services were provided by the ACO;
- How will global payments be allocated among members of the ACO; and
- How soon an ACO will be expected to take on risk, how much risk an ACO will be expected to accept, and will carriers will be required to make additional payments if an ACO fails to meet its budgeted level.

In addition to addressing these questions, the Commission's recommendations should recognize a number of other considerations related to the formation of ACOs and the development of global payments:

- There needs to be a "menu" of payment approaches beyond global payment. These other approaches, which could include shared savings models, may be a transition step to global payments or, in some cases, may be a more permanent approach;
- Provider participation in an ACO needs to be voluntary;
- There should be common reporting requirements related to global payments to ensure consistency across providers and payors; and
- There are challenges to implementing global payments for Preferred Provider Organizations (PPO) plans and self-insured plans. Requiring individuals enrolled in PPO plans, whether fully or self-insured, to choose a PCP may be more challenging than anticipated. For example, it is not clear how providers could be held accountable when patients can self-refer outside the ACO. In addition, there are legal barriers to self-funded plans participating in global payment arrangements, either on a voluntary basis or by state

mandate. To the extent that self-funded plans do not participate in global payment arrangements, steps may need to be taken to prevent providers from shifting costs onto self-insured plans as a mechanism to offset rates paid as a part of a global payment for other product lines.

#### **Support for ACOs**

While infrastructure investments may be needed, they should be shared across the health care system including utilizing existing resources as the costs required to build and maintain the infrastructure for all providers may not be feasible. Health plans are in the position to be able to capture such information on a much larger population than individual provider entities, and the report should place an emphasis on collaboration and data sharing between health plans and provider entities, rather than requiring multiple administrative build-outs across providers that may duplicate existing health plan activities. The report should include criteria for providers to be deemed to be in need of infrastructure support, with the criteria taking into account the size of providers and scalability of the infrastructure necessary and should include an overview of the expected sources of and costs for infrastructure support.

#### **Transition Oversight/Successor Entity**

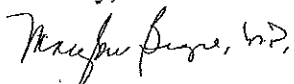
It is important for government to play a role to prevent monopolistic rate setting. The creation of ACOs could lead to further provider consolidation, resulting in providers having even more bargaining power than they do today and driving up costs. We appreciate that the draft recommendations include a reference to market share in defining the parameters of an ACO and the final report should provide additional detail by directing the successor entity to monitoring the creation of ACOs to ensure that the change in the provider system does not lead to further consolidation.

While the draft recommendations charge the successor entity with setting targets to provide greater payment equity and for monitoring market conditions, the final report should acknowledge that there may be instances where health plans and providers cannot reach agreement and charge the successor entity to develop an approach for such instances. Where health plans and providers cannot reach agreement as to payment methodology or rates, one approach would be to set payments based on a default fee-for-service payment rate tied to a national standard, such as a set percentage of Medicare rates, and require that the parties have to accept the rate until they reach an agreement.

In addition to outlining the steps necessary to move to a global payment system, the report should include an overview of how success will be defined and we believe that controlling costs must be one measure by which success is measured. Towards that end, the report should include some projections of what the estimated cost savings would be and the feasibility of implementing this model or direct the successor entity to determine this based on financial modeling of moving to a system of global payments. Finally, the report should include a requirement for an advisory commission comprised of stakeholder representatives that the successor entity would consult with as it develops and reviews its milestones in transitioning to global payments, so that any necessary changes can be made based on feedback from those implementing this model.

Again, we appreciate the opportunity to offer additional comments and look forward to the Commission's final report.

Sincerely,



Marylou Buyse, MD  
President

cc: Michael Bailit, President, Bailit Health Purchasing